



6712-01

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 54

[WC Docket No. 02-60; DA 12-1166]

Wireline Competition Bureau Seeks Further Comment on Issues in the Rural Health Care Reform

Proceeding

AGENCY: Federal Communications Commission.

ACTION: Proposed rule; solicitation of comments.

SUMMARY: In this document, the Wireline Competition Bureau (the Bureau) seeks to develop a more robust record in the pending Rural Health Care reform rulemaking proceeding, which will allow the Commission to craft an efficient permanent program that will help health care providers exploit the potential of broadband to make health care better, more widely available, and less expensive for patients in rural areas.

DATES: Comments are due on or before August 23, 2012. Reply comments are due on or before September 7, 2012.

ADDRESSES: Interested parties may file comments on or before August 23, 2012 and reply comments on or before September 7, 2012. Comments are to reference **WC Docket No. 02-60 and DA 12-1166** and may be filed using the Commission's Electronic Comment Filing System (ECFS). See Electronic Filing of Documents in Rulemaking Proceedings, 63 FR 24121 (1998).

- Electronic Filers: Comments may be filed electronically using the Internet by accessing the ECFS: <http://fjallfoss.fcc.gov/ecfs2/>.

Paper Filers: Parties who choose to file by paper must file an original and one copy of each filing. If more than one docket or rulemaking number appears in the caption of this proceeding, filers must submit two additional copies for each additional docket or rulemaking number.

- All hand-delivered or messenger-delivered paper filings for the Commission's Secretary must be delivered to FCC Headquarters at 445 12th St., SW, Room TW-A325, Washington, DC 20554. The filing hours are 8:00 a.m. to 7:00 p.m. All hand deliveries must be held together with rubber bands or fasteners. Any envelopes and boxes must be disposed of before entering the building.
- Commercial overnight mail (other than U.S. Postal Service Express Mail and Priority Mail) must be sent to 9300 East Hampton Drive, Capitol Heights, MD 20743.
- U.S. Postal Service first-class, Express, and Priority mail must be addressed to 445 12th Street, SW, Washington DC 20554.
- People with Disabilities: To request materials in accessible formats for people with disabilities (braille, large print, electronic files, audio format), send an e-mail to fcc504@fcc.gov or call the Consumer & Governmental Affairs Bureau at 202-418-0530 (voice), 202-418-0432 (tty).

FOR FURTHER INFORMATION CONTACT: Chin Yoo, Telecommunications Access Policy Division, Wireline Competition Bureau at (202) 418-0295 or TTY (202) 418-0484. For detailed instructions for submitting comments and additional information on the rulemaking process, see the SUPPLEMENTARY INFORMATION section of this document.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Wireline Competition Bureau's Public Notice in WC Docket No. 02-60; DA 12-1166, released July 19, 2012. The complete text of this document is available for inspection and copying during normal business hours in the FCC Reference Information Center, Portals II, 445 12th Street, SW., Room CY-A257, Washington, DC 20554. The document may also be purchased from the Commission's

duplicating contractor, Best Copy and Printing, Inc., 445 12th Street, SW., Room CY-B402, Washington, DC 20554, telephone (800) 378-3160 or (202) 863-2893, facsimile (202) 863-2898, or via the Internet at <http://www.bcpweb.com>.

1. In this document, the Wireline Competition Bureau seeks to develop a more robust record in the pending Rural Health Care reform rulemaking proceeding, particularly with regard to the proposed Broadband Services Program. The Commission's Rural Health Care Pilot Program has helped foster the creation and growth of numerous state and regional broadband networks of health care providers (HCPs) throughout the country. These Pilot project networks have enabled health care providers in rural areas to tap into the medical and technical expertise of other health care providers on their networks, using telemedicine and other telehealth applications to improve the quality and lower the cost of health care for their patients in rural areas. As the Commission moves forward with reform of the Rural Health Care (RHC) program, it can benefit greatly from the experience of the Pilot projects and the lessons learned in the Pilot Program. A more focused and comprehensive record will help the Commission craft an efficient permanent program that will help health care providers exploit the potential of broadband to make health care better, more widely available, and less expensive for patients in rural areas.

2. In its March 16, 2010, Joint Statement on Broadband, the Commission said that "ubiquitous and affordable broadband can unlock vast new opportunities for Americans, in communities large and small, with respect to . . . health care delivery." The National Broadband Plan issued that same day recommended, among other things, that the Commission reform its Rural Health Care program in two ways: (1) by replacing the existing Internet Access Fund with a Health Care Broadband Access Fund, and (2) by establishing a Health Care Broadband Infrastructure Fund to subsidize network deployment for HCPs where existing networks are

insufficient. Later that year, the Commission issued a Notice of Proposed Rulemaking in this docket proposing, consistent with the National Broadband Plan recommendations, both a Health Infrastructure Program, which would support the construction of new broadband HCP networks in areas of the country where broadband is unavailable or insufficient, and a Health Broadband Services Program, which would support the monthly recurring costs of broadband services for rural HCPs.

3. Since the Commission issued the NPRM in 2010, the rural health care Pilot projects have made additional progress toward full implementation of their health care broadband networks. Although the Commission allowed Pilot projects to receive support to construct and own broadband network facilities, many Pilot projects chose to lease broadband services from commercial service providers as a way to implement broadband networks connecting HCPs. Projects chose to lease services instead of building networks because HCPs did not want to own or manage the networks and could more easily obtain needed broadband without owning the facilities or incurring administrative and other costs associated with network ownership. In light of the number of successful projects that elected to lease services instead of constructing networks, this public notice focuses on deepening the record regarding the Commission's proposed Broadband Services Program and the participation by consortia, including Pilot projects, in such a program.

4. In recent months, Commission staff has engaged in outreach calls and meetings with many Pilot projects, as well as with other entities knowledgeable about rural health care, telemedicine, and Health IT. Based on what we have learned from the Pilot projects, and in light of the comments and other information filed in this Docket, we have identified several areas relating to the Broadband Services Program proposed in the NPRM that would benefit from

further development of the record: (1) use of consortium applications; (2) inclusion of urban health care providers in funded consortia; (3) services and equipment to be supported; (4) use of competitive bidding processes and multi-year contracts; and (5) broadband needs of rural health care providers. We are especially interested in obtaining input that reflects the experience of participants in the Commission's current Rural Health Care programs, particularly that of the Pilot Program participants. To the extent possible, parties should identify throughout their comments the particular public notice questions to which they are responding, by using the relevant section numbers and letters (for example, "Section I.a. --Consortium application process").

I. CONSORTIA

5. Section 254(h)(7)(B)(vii) of the Communications Act specifically authorizes funding for consortia of eligible health care providers. Commenters suggest that the consortium approach has many benefits, especially for rural HCPs that have limited administrative, financial, and technical resources. Although a health care provider may apply for funding under the existing Rural Health Care telecommunications program or Internet access program (collectively, "Primary Program") as a member of a consortium, in practice consortium applicants in the Primary Program must still file a separate form for every HCP site, and thus the consortium process has not been as widely used in that program as it has in the Pilot Program.

6. In the NPRM, the Commission recognized that many Pilot projects, which are consortia of HCPs, may wish to transition to the permanent Broadband Services Program, if adopted, and sought comment on that transition. We now seek to further develop the record on issues relating to the use of consortium applications in the proposed Broadband Services Program:

- a. Consortium application process. We seek comment on specific procedures for the application process for consortia in the proposed Broadband Services Program and ask commenters to focus on how to streamline the application process while protecting against waste, fraud and abuse. What specific information should the Commission require from the consortium leader regarding each consortium member on the application forms? Should letters of authorization (LOAs) from participating members of the consortium be required? If so, should LOAs be submitted at the request-for-funding-commitment stage (with the filing of the Form 466-A), rather than at the request-for-services stage (with the filing of the Form 465), as is now the case under the Pilot Program? Submitting the LOAs later in the process, with the Form 466-A, would appear to be more administratively efficient for the consortium, because the consortium could wait until it had completed competitive bidding and knew the pricing before soliciting the LOAs. Before they know the pricing, health care providers are likely to be less certain about whether they will want to participate. This approach also would be administratively simpler for USAC, as USAC would only have to confirm eligibility for that smaller group of HCPs that already know the pricing and are therefore more sure that they want to participate. We also seek comment on the alternative of requiring HCP LOAs to be submitted at the earlier (Form 465) stage, as in the Pilot Program. Should the Commission require consortium applicants to provide details in the consortium's request for services (the Form 465) regarding the services to be purchased, such as the desired bandwidth, sites to be served, and general type of service, as is currently required in the Pilot

Program? Should the Commission require the lead entity and selected vendor to certify that the support provided will be used only for eligible purposes, as it does in the Pilot Program in connection with Form 466-A? Should the Commission require applicants to submit a “declaration of assistance,” as is required with the Form 465 in the Pilot Program? We encourage commenters to draw on their experience with the Pilot and Primary programs in supporting any recommendations for streamlined application procedures.

- b. Post-award reporting requirements. What is the least burdensome way to collect information necessary to evaluate compliance with the statute and other relevant regulations, and to monitor how funding is being used? Should the Commission require consortium applicants to submit Quarterly Reports, as in the Pilot Program? Would the same information that is required for single HCP applicants be required for each HCP in a consortium application, or should the Commission permit consortium applicants to submit a reduced amount of information for each HCP, as it did in the Pilot Program? We encourage commenters to draw on their experience with the Pilot and Primary Program in supporting any recommendations for streamlined reporting procedures.

- c. Site and service substitution. The Pilot Program permits site and service substitutions within a project in certain specified circumstances, in order to provide some amount of flexibility to project participants. Under the Pilot Program, a site or service substitution may be approved if (i) the substitution is determined to be provided for in the contract, be within the change clause, or constitute a minor modification, (ii) the site is an eligible health care provider or

the service is an eligible service under the Pilot Program, (iii) the substitution does not violate any contract provision or state or local procurement laws, and (iv) the requested change is within the scope of the controlling FCC Form 465, including any applicable Request for Proposal. Should the Commission adopt a similar policy for consortia that participate in the Broadband Services Program, if adopted? Would any modifications to that policy be warranted for the Broadband Services Program?

II. INCLUSION OF URBAN SITES IN CONSORTIA

7. One of the benefits of facilitating the establishment and operation of health care networks that serve providers in rural America is improved access to specialized care that typically is more available in urban areas. Historically, support under the Primary Program has only been provided to health care providers that meet the rural health care mechanism's definition of "rural." In the Pilot Program, however, the Commission permitted non-rural health care providers to participate as part of consortia that include health care providers serving rural areas.

8. In response to the NPRM, a number of commenters and USAC identify many benefits from including public and not-for-profit urban (or "non-rural") health care providers in rural broadband health care networks. Urban providers have taken the lead in many of the Pilot projects, and commenters note that many urban HCPs also provide technical, financial, and administrative support that otherwise might be unavailable to rural HCPs. Commenters have also noted that urban locations typically have medical specialists and other resources that rural HCPs need to access, through telemedicine and other telehealth applications. To further develop the record in the rulemaking docket, we now seek more focused comment on issues relating to

the participation of urban HCPs in consortia that serve rural health care needs as part of the Broadband Services Program, if adopted.

- a. Proportion of urban or rural sites in consortia. The 2007 Pilot Program Selection Order allowed urban HCPs to receive support under the Pilot Program as long as they were part of networks that had more than a de minimis number of rural HCPs on the network. If the Commission were to provide support for broadband services to urban HCPs that are members of consortia that serve rural areas, should it adopt specific rules to ensure that the major benefit of the program flows to rural HCPs and/or to rural patients? For example, should the Commission require that more than a de minimis number of rural HCPs be included in such consortia, as in the Pilot program, and if so, what specific metrics should be used to determine whether a sufficient number of rural HCPs are participating in the consortia? For instance, should the Commission specify a maximum percentage of urban sites within a consortium? USAC states that urban sites make up approximately 35 percent of all HCP Pilot Program sites that received funding commitments as of January 2012. Should the Commission adopt this or a different percentage as an upper limit on the proportion of urban HCP sites within the rural health care program overall or within a consortium?
- b. Limiting percentage of funding available to urban sites. In the alternative, should the Commission specify a maximum amount of funding that can be provided to urban sites within a consortium? USAC estimates that about 35 percent of committed funds have gone to urban HCPs in the Pilot Program (while noting that this figure probably overstates the true urban share). Given

that the Commission has sought comment on how to transition Pilot Program participants into a reformed program, would adopting a requirement that urban sites receive no greater than 35 percent of total funds per funding year be a workable and appropriate restriction? How would the existence of such limits on urban site funding or inclusion of urban sites affect the consortium planning process and the development and growth of consortia over time?

- c. Impact on Fund. To the extent commenters support a particular approach to limiting the participation of urban sites in consortia serving rural areas, they also should estimate the likely impact on the RHC funding mechanism if the Commission were to adopt their recommended approach. Commenters should provide data to support their estimates. We welcome detailed analysis on the impact on the Fund of any limits (or lack thereof) on urban HCP participation that the Commission may adopt or that parties may propose.
- d. Impact on network design. USAC notes that in the hub-and-spoke configuration common to Pilot projects, where a centralized or primary HCP serves as the main provider and is surrounded by several subsidiary providers, the hub is often an urban HCP. What impact would including (or excluding) urban sites from funding under the Broadband Services Program have on network design and efficiency, from both a cost perspective and a technological perspective? Would it be possible to limit funding for urban sites to recurring and non-recurring charges associated with equipment necessary to create hubs at urban HCP sites? Would such a limitation unnecessarily restrict participation by urban HCPs or otherwise limit the effectiveness of the program?

- e. Role of urban health care providers if not funded. There may be significant benefits to Pilot projects from having a project leader that handles administrative and other necessary tasks on behalf of the other project participants. If the Commission were to exclude urban sites that are part of consortia serving rural communities from receiving funding under the Broadband Services Program, would there be administrative benefits to allowing such urban providers still to serve as project leaders even though they do not receive any support? In response to the NPRM, some commenters and Pilot projects contend that without support from the RHC program, urban sites may be reluctant to participate in broadband networks with rural HCPs, which could undermine the ability of rural HCPs to interconnect with those urban sites and to draw on their technical and medical expertise. What incentives would urban providers have to participate as a project leader if they are unable to receive any support?
- f. Grandfathering of urban sites already participating in Pilot projects. If the Commission chooses not to provide funding to urban sites under the Broadband Services Program, or sets limits on such funding as discussed in paragraph (b) above, should the Commission nevertheless provide funding to urban sites that have received funding under existing Pilot projects? Should the Commission limit the funding to existing Pilot project urban sites only for so long as the urban site is a member of a consortium with rural HCPs?

III. ELIGIBLE SERVICES AND EQUIPMENT

9. In the Pilot Program, the Commission allows health care providers to use “any

currently available technology” in order to create networks. The Pilot Program funds both recurring costs and non-recurring costs (NRCs) for dedicated broadband networks connecting HCPs in a state or region, including the cost of subscribing to commercial service providers’ services. As noted above, although the Pilot Program permitted projects to construct and own broadband network facilities, many projects elected to lease broadband services (which mostly involve recurring costs) rather than constructing and owning the broadband facilities themselves. As of February 29, 2012, the Pilot Program had committed approximately \$35 million for construction, \$162 million for leased/tariffed facilities or services, and \$19 million for network equipment (including engineering and installation). The projects choosing to lease services cite several reasons for that choice, including that the HCPs’ core competencies does not include owning or managing communications networks, that the HCPs can obtain the needed broadband without owning the facilities themselves, and that the administrative and other costs associated with broadband network ownership are too great.

10. For the Broadband Services Program, the NPRM proposed to fund “recurring monthly costs for any advanced telecommunications and information services that provide point-to-point connectivity, including Dedicated Internet Access.” In light of the Pilot Program experience and the comments in the record, we seek more focused comment on questions related to this proposal.

- a. Point-to-point connectivity. Some commenters have raised concerns regarding the term “point-to-point” in the NPRM. We seek to further develop the record on the types of connectivity that should be eligible for support under the proposed Broadband Services Program. Health care networks and other enterprise customers use a wide variety of connectivity solutions which allow a variety of

topologies (ring, mesh, hub-and-spoke, line, etc.) and technologies (MetroE, MPLS, Virtual Private Network, etc.) to meet their requirements. These solutions are “point-to-point” in the sense that they allow a facility to send or receive data to or from another facility, but they also provide additional capabilities -- for example, the ability to connect to multiple facilities on the same network, and/or the ability to connect to another facility without needing a physically “dedicated” circuit to that facility. Should the definition of services to be funded under the Broadband Services Program omit the phrase “point-to-point”? We seek comment on whether the rules for the Broadband Services Program should enumerate a wide range of connectivity solutions such as those listed above, or should be more general, in recognition of the likely change and evolution of services utilized by health care providers that will occur over time. Should there be any distinction in the types of services that would be funded if the applicant is part of a consortium, as opposed to individual applicants?

- b. Eligible non-recurring costs (NRCs). For the Broadband Services Program, the Commission proposed in the NPRM to provide one-time support for 50 percent of reasonable and customary installation charges for broadband access and to provide support for the cost of leases of lit or dark fiber. The American Telemedicine Association has recommended that the Commission, at a minimum, support the costs of routers and bridges associated with the installation of broadband services to an eligible health care provider, and that the Commission allow such providers to work together to purchase equipment through joint, cooperative bidding procedures in order to allow for more efficient purchasing of

network equipment costs. USAC notes that the availability of funding for certain types of equipment in the Pilot Program (“servers, routers, firewalls, and switches”) facilitates the ability of health care providers to upgrade circuits or create private networks. We seek more focused comment on whether the NRCs eligible to receive support under the Broadband Services Program should include equipment to enable the formation of networks among consortium members, similar to the Pilot Program.

c. Limited Funding for Construction of Facilities in Broadband Services Program.

As noted above, most Pilot projects chose to lease services rather than to construct and own their own network facilities. Some Pilot projects nevertheless argue that they need the option of constructing their own facilities when no service provider is willing to construct broadband facilities and lease them to project participants, or when the bids a project receives for leased services are higher than the cost of construction. The NPRM proposed a Health Infrastructure Program that would fund the construction of dedicated broadband networks in areas where broadband is demonstrated to be unavailable, and would require HCPs to have an ownership interest in the network facilities funded by the program. The Broadband Services Program, in contrast, would provide funding only for broadband services and, as proposed, would not cover capital or infrastructure costs. We seek to further develop the record on whether it would be appropriate under the proposed Broadband Services Program, if adopted, to provide funding to recipients to construct and own network facilities under limited circumstances. Would it be appropriate, for instance, in a situation where the applicant could demonstrate that

self-provisioning the last mile facility to connect to an existing health care network is more cost-effective than procuring that last mile connectivity from a commercial service provider? What requirements would need to be in place to ensure that construction and ownership is the most cost-effective option? How would a health care provider or consortium make such a showing? Would it be necessary to wait until after the competitive bidding process is completed in order for an applicant to be able to make that showing? Are there other more preliminary milestones during the competitive bidding process after which an applicant could make a showing? If the Commission were to make this option available, should there be specific caps on funding available to construct HCP-owned facilities?

- d. Ineligible sites and treatment of shared services/costs. Section 254(h)(3) of the Act and § 54.671(a) of the Commission's rules restrict the resale of any services purchased pursuant to the rural health care support mechanism. In the Pilot Program, the Commission determined that, under this resale restriction, a selected participant could not sell network capacity that was supported by Pilot Program funding, but could share excess network capacity with an ineligible entity as long as the ineligible entity paid its "fair share" of network costs attributable to the portion of the network capacity used. In the Pilot Program, projects have allocated the cost of shared services and equipment among members (both eligible and ineligible HCPs) by taking into account a variety of healthcare-specific factors. We note that in the Pilot Program, projects submit information

about sharing of services and costs among members with their requests for funding commitments, and that USAC reviews and approves those submissions.

We seek comment on whether there is a need to adopt specific rules in the Broadband Services Program (if adopted), regarding the participation of ineligible HCP sites (e.g., for-profit rural health clinics or, if not included in the Broadband Services Program, urban HCPs) in consortia that receive funding for broadband services provided to eligible members. Even if not funded, there may be other health care and financial reasons why providers that are not funded through the program may wish to enter into cooperative arrangements with other providers that are funded, in order to create local and regional health care networks. By acting together, providers are more likely to receive lower pricing and a wider array of services to meet their health care needs. Should the Broadband Services Program have a “fair share” requirement comparable to the Pilot Program? In particular, should the Commission adopt a specific approach to shared services and costs for consortium applicants, or should the Commission just require that the allocation of the costs of shared services and equipment among consortia members be reasonable? We welcome further comment on whether the procedures utilized by USAC to implement the fair share requirement in the Pilot Program are workable or burdensome, and what measures would best address potential waste, fraud and abuse in a reformed program.

IV. COMPETITIVE BIDDING PROCESS AND RELATED MATTERS

11. The Pilot Program requires projects to prepare Requests for Proposals (RFPs) and to use a competitive bidding process to select broadband infrastructure and service providers. It

appears that the competitive bidding process, in combination with bulk purchasing by a large number of health care providers using a single RFP, has led to lower prices, better service quality, and more broadband deployment than the individual HCPs might otherwise have obtained. In the NPRM, the Commission proposed to extend the competitive bidding requirements currently applicable to the Primary Program's Internet access program to the Broadband Services Program, and sought comment on changes that could be made to make the competitive bidding mechanism more successful or efficient. We now seek more focused comment on issues relating to the competitive bidding process.

- a. Competitive bidding process. Building on the experience gained from the Pilot Program, what specific requirements should be in place for competitive bidding in the Broadband Services Program, if adopted? Should the Commission require consortium applicants in the Broadband Services Program to prepare a Request for Proposal (RFP), as applicants in the Pilot Program were required to do? Should the Commission exempt consortia from the RFP requirement if they are applying for less than a specified amount of support (for example, if they are applying for less than \$100,000 in support)? Are there other elements of the competitive bidding process utilized in the Pilot Program that should be applied to the Broadband Services Program, either as is or with changes that the parties suggest to improve the process? Are there any competitive bidding requirements used in the Schools and Libraries Universal Service Support Mechanism that the Commission should apply to the Broadband Services Program, if adopted?
- b. Requirement to obtain competitive bids. Some commenters indicate individual rural HCPs may decide not to seek RHC support due to the added administrative

burden associated with the competitive bidding process. The Virginia Telehealth Network (VTN) states that many rural HCPs are in areas served by a single broadband provider, where competitive options do not exist. Based on USAC's data, approximately 11 percent of RHC Primary Program applicants outside Alaska receive bids in the competitive bidding process. In response to the NPRM, VTN recommends that the Commission consider a streamlined service provider selection process for HCPs that do not have multiple broadband service options, such as simply requiring an HCP to submit a simple certification of its efforts to identify all broadband providers and a description of the broadband service option selected. In the Broadband Services Program, should competitive bidding only be required for consortium applicants, given the experience to date with the current competitive bidding requirement for individual HCPs in the Primary Program? We particularly seek comment on this question from HCPs who have experience with competitive bidding as individual HCPs in the Primary Program. Should the Commission consider not applying a competitive bidding requirement to individual applicants who request only a limited amount of funding? Are there any other applicants that the Commission should exempt from competitive bidding requirements under a Broadband Services Program, if adopted?

- c. Multi-year contracts. Participants in the Primary Program must submit funding requests annually, but may obtain "evergreen" status for certain multi-year contracts. Participants with evergreen contracts are not required to go through the competitive bidding process annually. In contrast, Pilot Program participants

were awarded a set maximum award for a multiple-year period and permitted to carry over unused funds from year to year during the duration of the award, which has reduced the paperwork they needed to file and may have allowed them to lock in stable prices for several years. Notably, a significant number of Pilot participants opted to make use of long-term prepaid leases and indefeasible rights-of-use (IRU) arrangements. For the Broadband Services Program, the Commission proposed to allow evergreen contracts, similar to those allowed in the Primary Program, and also to allow funding for the lease of lit or dark fiber, which is typically purchased under an IRU corresponding to the useful life of the fiber.

Commenters have suggested that the Commission could encourage high capacity broadband networks that would support health care providers' telemedicine and broadband needs by allowing HCPs to enter into long term contracts for such networks with carriers or other telecommunications providers. We seek comment on the benefits and drawbacks of providing funding for multi-year contracts, including long-term prepaid leases and IRUs, in the Broadband Services Program. The Nebraska Statewide Telehealth Network (NSTN) recommends that a "true" evergreen provision be applied to HCPs with multi-year contracts, which would allow for HCPs with multi-year contracts to apply only once for multiple years of funding.

Would permitting evergreen contracts (as they are implemented today, with the annual filing requirement) be sufficient to allow consortia in the Broadband Services Program to reap the potential benefits of multi-year contracts,

while minimizing administrative burdens? Or, would evergreen status need to be coupled with a multi-year award, and if so, would three years be sufficient for the term of the award, or would some other period be more appropriate? We note that long-term prepaid leases and IRUs generally involve a large, upfront payment. For example, the full cost for a dark fiber IRU is typically paid for in advance. If the Commission permitted long-term prepaid leases and/or IRUs in the Broadband Services Program, how should it deal with upfront payments? How would funding multi-year contracts impact the calculation and forecasting of demand for RHC support? What protections should be put in place to protect against waste, fraud and abuse? For instance, would the measures used in the Pilot Program for such arrangements be useful in the Broadband Services Program (such as sustainability plans, minimum contract length, and repayment requirements)? If so, should those same measures be used, or should they be modified in any respect?

- d. Existing Master Services Agreements (MSAs). MSAs permit applicants to opt into a contract for eligible services that have been negotiated by federal or state government entities without having to engage in negotiations with individual service providers. The U.S. Department of Health and Human Services has recommended that the Commission exempt from competitive bidding requirements federal health care providers (such as the Indian Health Service) that are required to use the General Services Administration Networx contract for telecommunications services. Should the Commission permit applicants for the Broadband Services Program to take services from an MSA, so long as the

original master contract was awarded through a competitive process? What specific rules should be in place (e.g., an exception to the competitive bidding requirement) in order for HCPs to take advantage of MSAs? Should Pilot program participants that have exhausted Pilot program funding be able to obtain support from the Broadband Services program for services pursuant to MSAs that were negotiated by the Pilot projects?

- e. Eligible service providers. The NPRM proposed that broadband services supported by the Broadband Services Program may be provided by “a telecommunications carrier or other qualified broadband access service provider.” In response to the NPRM, some Pilot participants expressed concern that this definition would be too narrow, as it might exclude some vendors that responded to RFPs issued by project participants. In the Pilot Program, a wide range of service providers responded to the RFPs issued by the project participants, including telecommunications carriers and companies in the fields of systems integration, optical networking, utilities, construction, electronics and equipment. We seek more focused comment on the specific definition that should be adopted in our rules for eligible providers under the Broadband Services Program, if adopted.

V. BROADBAND NEEDS OF RURAL HEALTH CARE PROVIDERS

12. Both the National Broadband Plan and the GAO Report emphasized the importance of determining the broadband needs of health care providers as part of the Commission’s reform of its rural health care program. A number of parties have commented on the broadband needs of health care providers, and USAC has filed an informal needs assessment. In light of

developments since the issuance of the NPRM, we seek to refresh the record on various questions relating to the broadband needs of rural HCPs, with particular attention to how the answers may vary based on the size and type of HCP, and how the broadband needs may change over time.

- a. Telemedicine. What bandwidth is needed for various types of telemedicine applications? In particular, how widespread is the use of teleradiology, and what bandwidth is required? How widespread is the use of videoconferencing in providing telemedicine, and what bandwidth is required? Will broadband needs associated with telemedicine likely change over time? What factors will cause the needs to grow? How important are connections between rural HCPs and urban HCPs?
- b. Electronic health records. How will the current trend toward adoption and exchange of electronic health records affect bandwidth needs? Congress has directed the Medicare and Medicaid programs to provide incentive payments for HCPs that have adopted electronic health records and have achieved “meaningful use” of those records, which includes some electronic exchange of those health records. Eventually, achieving “meaningful use” is expected to be mandatory for recipients of Medicare and Medicaid payments. What is the impact of “meaningful use” incentive payments and requirements on likely demand for broadband connectivity for rural HCPs? What is the likely impact of participation by rural HCPs in Health Information Exchanges?
- c. Other telehealth applications. What are the likely broadband needs for other telehealth applications (e.g., training and technical support for health care

purposes and health IT applications)?

- d. Service quality requirements. We also seek comment on the needs of rural HCPs for such service quality features as dedicated connections, redundancy, low latency, and lack of jitter. How much will these added levels of quality add to the cost of broadband services for HCPs? Will privacy and security requirements applicable to health care data exchange affect HCP broadband service quality needs?
- e. Cost savings from broadband connectivity. In the NPRM, the Commission recognized that the use of broadband by health care providers has the potential to enable them not just to provide higher quality health care but also to realize substantial savings in the cost of providing health care. Many of the Pilot projects report that the broadband connectivity made possible by the program helped to generate such cost savings. We solicit specific information regarding the nature and magnitude of cost savings that HCPs have been able to achieve through use of broadband, as well as information and data regarding potential for cost savings through telemedicine and other telehealth applications. Many of these cost savings are realized by the HCPs themselves, through reductions in the number of and length of hospital stays, through savings in patient transport costs, through savings in transportation costs and time for medical professionals, and through other Health IT applications (such as consolidation of billing and scheduling functions, transmission and remote storage of images and medical records, and video-based training of health care and health IT professionals). Some commenters note that telemedicine also creates the potential for rural HCPs to

increase revenues, because telemedicine can enable rural providers to treat more of their patients locally. Telemedicine also yields costs savings for patients and their families, who can avoid the cost of travel and loss of workdays by receiving treatment closer to home. Some of the cost savings from telehealth applications accrue not directly to the HCP or the patients, but rather to other governmental entities (through savings in Medicare and Medicaid expenditures) and to other participants in the health care system (such as private insurers). We solicit the submission of specific information on all these possible sources of cost savings, including cost data and any studies documenting cost savings.

VI. PROCEDURAL MATTERS

13. Interested parties may file comments and reply comments on or before the dates indicated on the first page of this document. Comments are to reference **WC Docket No. 02-60 and DA 12-1166** and may be filed using the Commission's Electronic Comment Filing System (ECFS). See Electronic Filing of Documents in Rulemaking Proceedings, 63 FR 24121 (1998).

- Electronic Filers: Comments may be filed electronically using the Internet by accessing the ECFS: <http://fjallfoss.fcc.gov/ecfs2/>.
- Paper Filers: Parties who choose to file by paper must file an original and one copy of each filing. If more than one docket or rulemaking number appears in the caption of this proceeding, filers must submit two additional copies for each additional docket or rulemaking number.

Filings can be sent by hand or messenger delivery, by commercial overnight courier, or by first-class or overnight U.S. Postal Service mail. All filings must be addressed to the Commission's Secretary, Office of the Secretary, Federal Communications Commission.

- All hand-delivered or messenger-delivered paper filings for the Commission's Secretary must be delivered to FCC Headquarters at 445 12th St., SW, Room TW-A325, Washington, DC 20554. The filing hours are 8:00 a.m. to 7:00 p.m. All hand deliveries must be held together with rubber bands or fasteners. Any envelopes and boxes must be disposed of before entering the building.
- Commercial overnight mail (other than U.S. Postal Service Express Mail and Priority Mail) must be sent to 9300 East Hampton Drive, Capitol Heights, MD 20743.
- U.S. Postal Service first-class, Express, and Priority mail must be addressed to 445 12th Street, SW, Washington DC 20554.
- People with Disabilities: To request materials in accessible formats for people with disabilities (braille, large print, electronic files, audio format), send an e-mail to fcc504@fcc.gov or call the Consumer & Governmental Affairs Bureau at 202-418-0530 (voice), 202-418-0432 (tty).

In addition, one copy of each pleading must be sent to each of the following:

- (1) Chin Yoo, Telecommunications Access Policy Division, Wireline Competition Bureau, 445 12th Street, S.W., Room 5-A441, Washington, D.C. 20554; e-mail: Chin.Yoo@fcc.gov; (2) Charles Tyler, Telecommunications Access Policy Division, Wireline Competition Bureau, 445 12th Street, S.W., Room 5-A452, Washington, D.C. 20554; e-mail: Charles.Tyler@fcc.gov.

14. This matter shall be treated as a “permit-but-disclose” proceeding in accordance with the Commission's ex parte rules. Persons making ex parte presentations must file a copy of any written presentation or a memorandum summarizing any oral presentation within two business days after the presentation (unless a different deadline applicable to the Sunshine period applies).

Persons making oral ex parte presentations are reminded that memoranda summarizing the presentation must (1) list all persons attending or otherwise participating in the meeting at which the ex parte presentation was made, and (2) summarize all data presented and arguments made during the presentation. If the presentation consisted in whole or in part of the presentation of data or arguments already reflected in the presenter's written comments, memoranda or other filings in the proceeding, the presenter may provide citations to such data or arguments in his or her prior comments, memoranda, or other filings (specifying the relevant page and/or paragraph numbers where such data or arguments can be found) in lieu of summarizing them in the memorandum. Documents shown or given to Commission staff during ex parte meetings are deemed to be written ex parte presentations and must be filed consistent with rule §1.1206(b). In proceedings governed by rule §1.49(f) or for which the Commission has made available a method of electronic filing, written ex parte presentations and memoranda summarizing oral ex parte presentations, and all attachments thereto, must be filed through the electronic comment filing system available for that proceeding, and must be filed in their native format (e.g., .doc, .xml, .ppt, searchable .pdf). Participants in this proceeding should familiarize themselves with the Commission's ex parte rules.

FEDERAL COMMUNICATIONS COMMISSION

Trent B. Harkrader,
Division Chief, Telecommunications Access Policy Division
Wireline Competition Bureau.

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